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ADOLECENT HISTORY FORM

DIRECTIONS: *Please fill out as completely as possibly. This will help me best meet your needs. Your answers are confidential.*

Patient Name: _____ Date: _____

*Gender identity:*_____

Presenting Problem: (Please circle all of your concerns)

Fear of hurting yourself	Irresponsible	Repetitive thoughts
Fear of hurting someone else	Irritable	Repetitive behaviors
Self-injury	Angry	Sees things others do not
Fire-setting	Sad most of the time	Hears things others do not
Legal problems	Fatigue	Difficulty getting to sleep
Traumatic event	Frequent mood changes	Difficulty staying asleep
Bed-wetting	Feeling anxious/fearful	Wanders during night
Harmful to animals	Tearful	Frequent nightmares
Argumentative	Easily distractible	Drug/alcohol use
Unable to keep friends	Difficulty concentrating	Tics/involuntary movements
Secretive	Impulsive	Pre-occupied with sex
Lying	Memory problems	Sexual problems
Stealing	Lacks confidence	Frequent complaints of illness
Aggressive toward others	Has lost interest in activities/friends	Appetite changes
Destructive to property	Prefers to be alone	Recent weight loss or gain
Access to weapons	Racing thoughts	Picky eater
Hopelessness	Confused a lot	Other
Helplessness	Overly energetic	
Blames others	Grandiose	

A: Family History:

	Lives you?
Mother's name:	Yes No
Father's name:	Yes No
Siblings name:	Yes No
Siblings name:	Yes No
Siblings name:	Yes No
Additional members:	Yes No

Do you live in a blended family? Yes No

Does religion play a significant role in your life/family? Yes No

B Environmental History: *(please circle all that applies currently or in the past).*

Death in the family	Financial stress
Unemployment of self or parent	Frequent moves
Parental illness	Emotional abuse
Crime victim	Parental separations or divorce
Violence at home	Violence between family members
Sexual abuse	Weapons in the home
Alcohol abuse self or parent	Other (please explain)

C: Mental Health History:

Have you ever hurt yourself or attempted suicide? If so, explain:

Have you ever been hospitalized for psychiatric reason? If so when and where?

Are you currently taking any medications for a psychiatric condition? If so name, dose and frequency?

Have you ever been in counseling? If so, when and with whom?

D: Alcohol and Drug History:

What, if any , drugs or alcohol are you currently using? If so, amount and frequency?

What if any, drugs or alcohol have you used in the past?

Do you smoke cigarettes? If so, quantity per day/week or month?

Has any family member had problems with alcohol or drugs? If so, who and when?

E: Employment History (16 years and older):

Do you have a job that earns money? Job title?

How many hours per week do you work?

F: Academic History: (please circle)

Victim of bullying/teasing	Feeling threatened	Low grades
Suspensions/expulsions	Special classroom	Failing grades
Under achievement	Over achievement	Learning disability
Social/behavioral problems	IEP/504	Skipping/poor attendance

Are you currently enrolled in school? If so, where and what grade are you in?

G: Legal History:

Have you ever had a legal problem or been involved with the police? If yes, explain.

H: Medical History:

a)Current medical problems/allergies:

b) Current medications (include dose and frequency)

c) Any past head injuries or serious physical trauma?

d). Nutritional history (please describe any dietary concerns):

Patient signature : Date: